Oak Cottage Care Ltd

Oak Cottage

Inspection report

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Date of inspection visit: 17 July 2014
Date of publication: 04/02/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

Oak Cottage is registered to provide residential care for up to 21 older people, some of whom live with dementia. There was a registered manager in place however, they did not oversee the day to day running of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The service was being run by three assistant managers, one of whom was available on the day of our inspection and one we spoke with after our visit.

The service offered a homely feel. People told us that they were happy there and that the staff were kind and caring. Staff knew people well and supported them appropriately. We observed that staff were attentive and patient with people.

Summary of findings

There were gaps in the recruitment procedures and also gaps in staff training. This meant that people could not be sure they were supported by safely recruited staff with the right skills and experience.

Some areas of people's care plans reflected individual needs and gave guidance to staff on how to support people. However, we also found that the care plans did not include assessments for skin integrity, nutrition or a person's ability to make decisions. People were not always involved in decision making about their care. Relatives were approached by the staff at the service who discussed and planned care with the management and staff team. Information about people, which included people's care plans, was not stored securely. This meant that personal information was accessible to people who were not permitted to access the information.

The systems in place for monitoring the quality of the service were not structured. The management were unable to demonstrate that they undertook reviews of such areas as care plans, the environment and staff training. Ths meant that the service did not have effective systems in place to regularly assess and monitor the quality of the service to ensure that people were protected against receiving care that is unsafe or inappropriate.

At this inspection we found the service to be in breach of Regulations 9, 10, 11, 17, 21 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People told us that they felt safe at Oak Cottage.

Recruitment procedures were not robust. The manager and staff had limited knowledge in regards to Deprivation of liberty Safeguards.

People had not received the appropriate assessments to ensure that care was planned and delivered in a way that promoted their safety and welfare.

Requires Improvement

Is the service effective?
The service was not effective.

People were supported to receive sufficient amounts of food and drink.

People had access to health care professionals.

Staff had not received up to date and relevant training for their role.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People were mostly positive about their care. People felt that their privacy and dignity were respected. However, this was not consistent and personal information was not always stored securely.

People were not involved in their planning care.

Requires Improvement

Is the service responsive?
The service was not responsive.

People and their relatives knew how to make a complaint. There had been no recent documented complaints.

Care plans were not personalised and the activities provided required improvement.

People had access to health care professionals and these were contacted when health concerns were identified.

Requires Improvement

Is the service well-led?
The service was not well led.

The registered manager was not involved in the day to day management of the service.

The quality assurance systems in place were not consistent and knowledge of these systems throughout the management team was inconsistent. Information requested by us was not provided.

Inadequate

Summary of findings

Systems were in place to obtain the views of people about the service. However, people were not aware of them.

Oak Cottage

Detailed findings

Background to this inspection

Prior to the inspection, we reviewed the information we held about the service. We had requested a 'Provider Information Report' (PIR) The PIR is a form that asks the provider to give some information about the service, what the service does well, improvements they plan to make and how they meet the five key questions. However, we did not receive this information.

The inspection was carried out by two inspectors and unannounced which means the provider and staff did not know we were visiting.

During our inspection we spoke with eight people who used the service, three relatives, a senior care assistant, two care assistants, the lead assistant manager, a second assistant manager, a visiting GP and district nurse and the contracts monitoring team. We looked at the records which included training records of staff, the care plans of three people who used the service and the personnel files for three staff members. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

People who used the service and their relatives told us that they felt staff were appropriately skilled and knowledgeable for their role. They told us that they would speak to the staff or one of the managers if they were worried about anything. Care staff were able to describe safe working practices and how to support people appropriately. However, we noted that some unexplained bruising had not been accurately recorded and had not been reported to the appropriate agencies. The manager was not aware of the need to investigate and report these occurrences.

The service had a copy of the local authority's safeguarding people from abuse policy, however, the assistant manager was not aware of this. The service's own policy required updating so that staff and people who lived in the home could be clear about who was responsible for carrying out investigations and external agencies who could be contacted if they were worried a person was at risk of abuse. The assistant manager was unclear about the process to be followed in the event of an allegation of abuse. They said they would speak with the lead assistant manager. Some of the staff demonstrated limited knowledge in the subject. This meant that people may not be protected from the risks of abuse because some staff had limited knowledge about safeguarding and the process to follow in the event of an allegation of abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We viewed staff files to see if the service had followed a robust recruitment procdure. Files included application forms, proof of identity and a copy of their job description. However, we found that gaps in employment had not been explored and explained in all of the files we viewed, nor was there a record of the interview and what it covered. We noted that one of the staff member's criminal record status had not been requested prior to them commencing employment or since being employed. We also saw that any anomalies on criminal record checks had not been discussed and therefore a risk assessment or manager decision had not been recorded. References had been obtained for new staff members however, these had not been verified.The assistant manager told us that there was no recruitment policy in place to ensure that they adhered to the appropriate recruitment requirements. This meant that the service could not ensure that staff employed to provide care for people were fit to do so.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. The assistant manager told us that they had not made any applications under the Deprivation of Liberty Safeguards (DoLS). We spoke with assistant manager and the staff about what circumstances they would apply for DoLS. They all had limited knowledge on the subject.This meant that they may not be able to recognise the need for a DoLS application or complete the process appropriately. Therefore people's rights may be restricted unlawfully.

People had not received the appropriate assessments to ensure that care was planned and delivered in a way that promoted their safety and welfare. There was no system in place to assess people's level of risk in relation to skin integrity and nutrition. The assistant manager and staff confirmed that this was the case. They told us an assessment would only be completed when a person displayed symptoms not as a preventative measure. This meant that a person who was at increased risk of developing a pressure ulcer or malnutrition may not be identified until it had impacted on their health. We also found that the assistant manager and staff were not aware that a pressure relieving mattress needed to be set according to the person's weight to provide safe and appropriate pressure relief. We saw that one mattress was set to double the weight of the person it had been provided for. Pressure relieving mattresses were turned off during the day which meant people were at risk of going to bed and lying on a mattress that was not fully inflated. The assistant manager told us that there was no mechanism in place for ensuring mattresses were at the correct setting for people's needs. This meant that people were at an increased risk of developing a pressure ulcer.

Accidents, incidents and trends were not monitored. Recording of these events was inconsistent and

Requires Improvement

Is the service safe?

investigations were not carried out. This also meant that action plans to reduce a reoccurrence had not been developed. Preventable accidents may not have been responded to appropriately which may have increased the risk to a person's safety and welfare.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were getting their needs met promptly most of the time. The assistant manager told us there was no formal system for assessing the staffing numbers required. They told us due to working closely with the team and supporting people they would identify an issue with staffing if it arose. However, during breakfast when staff were supporting people to get up, we observed that others had to wait for assistance and their breakfast until staff were free.

Requires Improvement

Is the service effective?

Our findings

People who used the service and their relatives told us some of the staff knew how to support them. One person said, “They are very good.” However, we were also told that some staff could be better.

Staff received regular supervision and there were plans in place to start a vocational qualification. The manager told us that staff were due to be enroled on the day of our inspection. However, tThe assistant manager told us, and records confirmed, staff had not all completed the relevant training. There had been some in house training relating to the common induction standards but other areas such as safeguarding people from the risk of abuse, moving and handling, pressure care, nutrition and dementia awareness, had not been covered. Staff spoken with had limited knowledge in some subjects. This meant that people may have been supported by staff without the required skills and knowledge to provide safe and appropriate care or support to meet people’s individual needs.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that the food they received was good and they received enough support to eat. One person told us, “It’s very good. I’m never really hungry, they make sure you have enough to eat.” Another person told us, “I have to have my food cut up.” A relative told us, “[Person] doesn’t like eating proper food, they are trying everything to get [them] to eat.” However, we noted that there were no menus available for people to choose from and there was one option of main meal each day. The manager and staff told us that they didn’t need to provide a second choice as they knew what people liked. This meant that changes to people’s tastes and preferences may not be accurately reflected.

People who required support with eating and drinking received the appropriate support from staff. However, we saw that where people were at risk of malnutrition or dehydration, there were no assessments in place to identify people’s level of risk prior to an issue being present. The staff told us that if someone’s weight or condition changed then they would commence a food and fluid intake chart and contact the GP. We noted that people’s weights were checked monthly and the records showed that they were generally stable. This meant that although staff were not assessing risk prior to it occurring, they were able to identify changes to a person’s welfare and act appropriately.

People told us that they had access to healthcare professionals. One person told us, “If I want to see one, they arrange it.” A relative told us, “They call the GP, who comes in once a week, if there’s a problem they call the district nurse. There’s a chiropodist when needed and a hairdresser.” Staff were clear on when they would need to contact and involve a GP, district nurse or specialist mental health team. One relative told us, “They [the staff] seem hot on that, slightest symptom, they call them in.” Visiting health care professionals told us that they did not have any concerns about the service and were positive about staff providing the appropriate support.

Requires Improvement

Is the service caring?

Our findings

People were mostly positive about the staff. One person told us, "They are very friendly, very kind, they come over to you to make sure you have everything." Another person told us, "I think they are very nice." However, one person told us, "You ask them for something they say they'll get it but you never get it." Relatives were all positive about the staff. One relative told us, "Wonderful, lovely girls. Definitely kind and caring."

People told us they felt, "Well presented." We overheard a staff member assisting a person with their toiletries and took extra time as the person didn't feel they had completed getting ready. The staff member was patient and kind. However, we observed this person having personal care with the bedroom door open. We also heard a staff member openly offer care with a continence aid in a busy communal lounge. We spoke with the assistant manager about this who told us that this had been an issue previously and that they had spoken to the staff member responsible. This meant that people's privacy and dignity was not always promoted.

Staff were kind and knew people well. However, although we observed staff asking permission before assisting people, we found that when it came to planning care or making decisions about care, the managers and staff involved the relatives rather than the person. There were several references about relative involvement in care plans and limited involvement of the person. For example, a person who had not been diagnosed with diabetes had been restricted on the number of sweets they could eat. Records showed, and the manager told us, that they had decided this action with the relatives even though there was not a mental capacity assessment or best interest's decision in place. The manager told us that this person had capacity to make their own decisions. Best interest decisions were not clearly documented and the manager and staff were not clear on the process around this. This meant that people were not involved in making decisions about their lives even when they had the ability and right to do so.

People's care plans were stored in the lounge in an open cupboard. We also saw information about people's bath schedules and dates of birth displayed in the reception area. This meant that this information was accessible to people who were not authorised to see this information and did not promote people's privacy.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service responsive?

Our findings

People told us that most staff asked them what they liked. However, most told us that their relatives spoke to the staff. This was expected as normal practice that relatives would make decisions rather than involving the person themselves. One person told us, "I just do what they tell me to do." Relatives of people who lived at the service told us that the staff involved them in the care planning. One relative said, "Totally involved, asked what we wanted for [person]. Asked about likes, dislikes, hobbies." This meant that people may have been receiving care and support that was preferred by their relative and may not have been in accordance with their preferences.

People's care plans did not consistently reflect their needs, preferences, life histories and health conditions. The care plans had several gaps and outdated information so did not support staff to provide effective and individualised care.

Staff had limited knowledge on the some of the needs they supported people with. As people's needs had increased or changed since living at the servive, staff had not been provided with additional knowledge or skills to meet those needs. However, one staff member told us if they had any concerns they called the district nurse or GP. Although we had identified that assessments for areas such as skin integrity and nutrition were not routinely completed, we saw that when a person presented change in these areas, care plans were written and advice was sought. For example, the district nurse was contacted if a person developed a pressure ulcer. The staff and assistant manager told us how this would then shape a person's care and the need to amend a care plan.

People who used the service and their relatives told us that they had not had reason to make a complaint but they would speak to one of the managers or carers if needed. The service had received no recent complaints so we were unable to see how they had responded to them. They told us that if a person or their relative had approached them with a 'minor' issue, then it was addressed immediately and staff were spoken with. For example, when a person had not had their personal coat hangers returned to their room. The manager did not keep a record of these issues and actions, however, staff we told us they had been spoken to about any issues.

The service completed annual relative surveys to assess the level of satisfaction with the service provision. The assistant manager told us that they carried out an analysis of the surveys and then completed an action plan. We asked for this information to be sent to us following the inspection. However, we did not receive it so were unable to see if actions arising from the survey were responded to appropriately.

People told us that activities were limited to things such as bingo, sitting and having a chat and an occasional singer. One person told us that there had been a barbeque recently and it was a nice change, another person told us they enjoyed their knitting. People had individual activity records which documented their involvement. However, we noted there were days where no activities or stimulation was provided The assistant manager told us they were planning to increase activity hours to ensure something happened each day. However, people were not supported to continue with previous, or new, hobbies as activities on offer were generic and did not reflect people's life histories, strengths and interests.

Inadequate

Is the service well-led?

Our findings

People who used the service and their relatives told us that the management team were visible and approachable. There was a registered manager in post, however, there were three assistant managers who had responsibility for the day to day management of the home. We met the one of the assistant managers on the day of our visit and spoke with the lead assistant manager following the visit.

The assistant manager responsible for the service on the day of our inspection told us that they monitored the service by visually checking daily during a tour of the premises, checking care records and speaking to people. No records were kept of these checks or actions taken as a result and there were no formal audits completed. We saw that there was a reference to these checks in notes of staff meetings. The assistant manager told us that they spoke to staff directly if issues were found. Staff corroborated that the managers walked round the building and provided feedback and guidance. However, the systems in place were not robust as during our inspection we identified several issues already identified previously by the management team and additional areas of concern. This meant the service were unable to demonstrate good management and leadership.

There was no formal systems in place to gather the views and comments of people who used the service. We saw that there were meetings held for staff regularly and less regular meetings held for people who used the service. The staff meetings covered various issues such as people's needs, preparing for an inspection and business information. The meetings for people who used the service were held on a one to one basis where a senior staff member or a manager spoke with every person who used the service and recorded if they were happy with the care and the food. All of the comments recorded a variance of the phrase, 'Likes living here, happy with the food'. There were no other quotes from people, discussions about activities or upcoming events and staff changes. People we spoke with could not recall attending any 'resident' meetings. This meant that these meetings were not held formally and people did not receive feedback and were not made aware of any actions arising from their comments. Therefore there was no record and people were not informed of how the service would be improved for them.

During our inspection we identified issues in a number of areas. This included that there were no assessments to identify potential risks, a lack of detail in people's care plans on how to manage the risks, improper use of pressure relieving equipment and staff recruitment procedures and training. The service was required to complete and submit the PIR prior to the inspection however, they told us that they had not received it We requested the report following the inspection but at the time of writing this report it had not been received.

The service did not have management systems in place to ensure that they notified us of events in the home such as deaths of people who used the service and serious injuries. We were told by the assistant manager that a person was currently in hospital following a fall and that there had been four people pass away whilst in hospital. We were unsure whether there had been any other notifiable events as the assistant manager was unable to locate the log of incidents and events.

Following the inspection we spoke with the lead assistant manager who was not present during the inspection. They said that the assistant manager who was in charge on the day of our inspection was not aware of the audits carried out. The lead assistant manager told us that they did carry out formal audits. We asked for them to be sent to us to support the inspection. However, we did not receive them and therefore were not able to corroborate that the monitoring had taken place.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1) (a) (b) (i) (ii) (iii)** **The service did not assess the needs of people who used the service to ensure their safety and welfare.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Regulation 11 (1) (a)** **The registered person had not ensured that staff were suitably trained to enable them to identify the possibility of abuse and respond appropriately.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Assessing and monitoring the quality of the service** **Regulation 10 (1) (a) (b) (2) (v) (3)** **The service did not have effective systems in place to assess and monitor the quality of the service to ensure the safety and welfare of people who used the service**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 17 (1) (a) (b) The registered person did not make suitable arrangements to ensure that people were enabled to participate in making decisions in relation to their care.
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Regulation 21 (1) (a) (i) (ii) The registered person did not operate effective recruitment procedures in order to ensure a person employed was of good character and had the qualifications, skills and experience necessary for the work to be performed.
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 (1) (a) The registered person did not ensure there were suitable arrangements in place to ensure that persons employed received the appropriate training to enable them to provide care or support to people safely and to the appropriate standard.